Social Problems and Critical Ethnomethodology*

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Abstract

I here explore the possibilities of critical ethnomethodology which stresses the practically indeterminate nature of indexical expressions[1]. According to Foucault, politics works through closure of the indefinite possibilities of a signifier to construct other possibilities as unthinkable. In this light, the seeming closure of meaning in everyday interaction turns out to be an outcome of the concerted workings of politics. In translating into Garfinkel's terminology, this closure is being accomplished in situ through the bona-fide membershipping practices.

For Garfinkel, the given-ness and natural-ness i. e. the objectivity of social structure which claims independence of the member's practice is through and through constituted by way of the member's organized practical judgmental activities which make intelligible the stable, recurrent social structure from within the local context. Moreover, this blending of ethnomethodology / conversation analysis and Foucault opens up a new and detailed analysis of the embodied politics constituting the conditions of the possibilities of actions.

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*The original draft of this paper was read at the 1999 annual conference of the SSSP held at Chicago. Thank you for the valuable comments given by the participants of the pacific sociological interaction session ; Drs. Jaber Gubrium, James Holstein and Gale Miller and the Japanese side of the coordinators Drs. Nobutoshi Nakagawa and Jun Ayukawa.

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meaning is accomplished as the concerted workings of politics and this gives new light on the conception of social problems.

I. The misconception of indexicality

It is widely held that Garfinkel's famous concept of indexicality suggests the impossibility of deciding the meaning of any utterance without the actual context of that particular utterance. However, if this would lead to the fine ethnography aiming at capturing the minute details of the context where the indexical expressions are embedded, that is utterly misconceived and misses the important points made by Garfinkel. Instead, indexicality does mean the specific moral and political bindings of the repairing activities of the local cohort in the specific state of membership ; i. e. seeming intelligibility of definite sense and henceforth acquired closure of signification belongs to the moral and political accomplishment of the judgmental dope. Let us trace this idea back to Garfinkel's earlier definition of the concept of member.

In the *Studies in Ethnomethodology,* Garfinkel's definition of member was based on Parsons' collectivity member so that this earlier definition stressed the moral bindings of the members' cognition of the social world[2]. He says, "for members, not only are matters so about familiar scenes, but they are so because it is morally right or wrong that they are so."[3] And he portrays the person who with a natural attitude, naively believes in the actual appearance of the world as "bona-fide collectivity member". The bona-fide members grasp the natural facts of life realistically and their commitment to knowledge of them is "a condition of self-esteem as a bona-fide and competent collectivity member."[4]

If we regard this bona-fide membership as a stable condition of the reproduction of the moral and social order, this leads to the portrayal of the actor following the

pre-established rules. Of course, this reminds us of the Durkheim's famous sociological rule that the social order is moral order which binds members together. However, according to Garfinkel, this way of portraying members is to make them "cultural dope"; by this term, he refers to "the man-in-the-sociologist's-society who produces the stable features of the society by acting in compliance with the stable features of the society by action in compliance with pre-established and legitimate alternatives of action that the common culture provides."[5)]

As shown in his famous breaching exercises, we can step out of the expected and legitimate courses of action and even enjoy the unexpected and anomaly consequences. Moreover, sociologists are not the only ones who portray the member as cultural dope; we too sometimes regard ourselves as cultural dope; "when one is actually talking about the anticipatory anxiety that prevents him from permitting a situation to develop, let alone confronting a situation, in which he has the alternative of action or not with respect to a rule."[6)] In short, We become cultural dope by our anticipatory fear and anxiety. It is interesting here that Garfinkel recommends that it is practically and theoretically important to master this fear. In short, the repair of indexical expressions means the closure of meaning and this is accomplished through the competent concerted work of judgmental dope.

II. Foucaldian Concept of Power Effects

In light of the above consideration, it becomes clear that the social order exerts forcible power over the possible courses of action as far as we remain cultural dope. The condition of cultural dope is the voluntary obedience to power on the basis of cultural fear. Foucault shows us the archeological layers of this anticipatory fear and in his terminology, this fear might be the subjectified agent itself starting to watch others as well as himself. Foucault thus portrays the custodial society which

constitutes itself with the fine web of power effects. According to him,

The exercise of power is not simply a relationship between partners, individual or collective ; it is a way in which certain actions modify others. Which is to say, of course, that something called Power, with or without a capital letter, which is assumed to exist universally in a concentrated or diffused form, does not exit[7]. Below is the following paragraph quoted from Foucault.

So that, the power exist only when it is put into action. It follows that the power is not a function of consent nor a form of violence. Rather the power is exercised only over free subjects, and only insofar as they are free. Thus, the point is that the exercise of power consists in guiding the possibility of conduct and putting in order the possible outcome. This function of power, as Foucault calls, is "the government" which is to structure the possible field of action of others. The relationship proper to power would not therefore be sought on the side of violence or of struggle, nor on that of voluntary linking (all of which can, at best, only be the instruments of power), but rather in the area of the singular mode of action, neither warlike nor juridical, which is government.

From the standpoint of the power effects, once the local cohort themselves have the competence to perceive the social situation appropriately, the participants to the situation are permeated by the fine power of culture[8]. In Sacksian terms, they are under the control of the categories of the predominant culture ; regardless of their subjective intentions, they are forced to take some particular forms of subjectivity, i. e. the acquired identity, respective relationships to others, and the specific repertories of the categorization appropriate to the relevant social situations. The members of the society accomplish this all by concerted praxis of local practical

reasonings i. e. culturally provided cognitive, judgmental work from within the society.

III. Two alternate practices of telling the hallucination

I would like to analyze one psychiatric interview and show how the closure of meaning is accomplished as the concerted workings of politics and this gives new light on the conception of social problems.

First, we witness the two alternate practices of telling the hallucination ; one is embedded in the institutionalized medical interview in mental hospital and the other is located in the closed informal talk occasionally encountered in the hospital ward or everyday life. The former constitutes the arena where the meaning of hallucination is deliberately constructed against the institutionalized psychiatric knowledge. And the latter could be glimpsed only for a cleavage of the institutional work flow which is otherwise repressed. I as a fieldworker of one mental hospital sometimes encountered this cleavage ; while the busy morning routines of ward activities (daily medical examination, preparation of the breakfast, disposal of the bed cover and sheets or etc) are finally finished, then comes the short period of inactivity ; nurses go out of the ward to do some clerical works and the patients go back to their beds and the silence dominates the ward. While I write down what has happened in the busy morning time in my field notes, it sometimes happens that one young patient who becomes acquainted with me through the interesting encounter comes next to me and after making sure if anybody overhears us, he starts to disclose his experience of hallucination. In order to gain continuing access to his experience, I should not interfere with his talking and just listen to him with a sign of agreement. This practice of just listening somehow constitutes a kind of trust between us and I had to keep this secret to other ward staff. And this

disclosure sometimes happens while we, alone together, take a walk outside the hospital[9].

I think this is the prerequisite condition that the experience of hallucination could be treated as non-medical object in mental hospital. In Foucauldian terms, we had to make deliberate efforts to stop putting hallucinating experiences under the surveillance of medical knowledge[10].

Now we look at the excerpt from the psychiatrist interview with the patient in a private mental hospital in Japan, the then Hitotsuse mental hospital at Miyazaki Prefecture. And in this we can see hallucinating experience under the surveillance of the power of psychiatry.

T : psychiatrist P : patient (Translated from Japanese so that the interrupting points are slightly different from the actual Japanese utterance. Thank you for the permission of tape-recording at Hitotsuse mental hospital at Miyazaki Prefecture.)

10T : We : : 1, what is the problem now ? Uh, the time of the discharge from the hospital ?

11P : Yes, the time of discharge from the hospital.

12T : Year.

13P : It should be a little bit shorter // I think.

14T : Year, but is it your original opinion ? Any one can say the same thing such that the shorter the better.

15P : Yes.

16T : Would you give me some other // reason ?

17P : While I stay here, clients would decrease. heh heh heh

18T : What ?

19P : If I continue to stay here, clients would decrease.

20T : If you stay here, clients would decrease ?

21P : Yes.

22T : Whose clients ?

23P : Clients of the outpatient clinic.

24T : We lose our clients ? What do you mean ?

25P : My thought is transmitted and what I see is seeable.

(1)

26T : Uh ha, what you see is seeable and ?

27P : Since eh : (1) the clients who come to this clinic, do not want the other people to know they come here.

28T : Year.

29P : So, the clients would like to avoid being seen by me, and that would cause the decrease in the numbers of clients.

30T : Oh, Those people who come to the mental clinic, would come here having anxiety that the other people should know they come here. However, as far as you stay here as an inpatient, the fact that they come to this clinic (1)

31P : would be disclosed. =

32T : =would be disclosed ? How ? Well, it is disclosed at least to you.

33P : It is disclosed to all.

(2)

34T : Why ? Why is it disclosed to all ? Do you tell somebody about it somewhere ?

35P : No. What I see is seeable to other people.

36T : Is it seeable to other people ?

37P : Yes.

38T : By seeable to other people, do you mean seeable without telling them what you see ?

39T : Yes.

40P : Without telling, what you see is seeable.

(2.5)

41P : Is it impossible ?

42T : Ah, well, uh : Would you please explain it in more detail ? What is it ?

43P : If I see a flower, the other people see the flower.

44T : Is it seeable to me, too ?

45P : Yes.

This excerpt starts with the topic concerning the discharge from hospital. And this topic is one of the typical categories which are relevant to custodial institutions such as the present Japanese mental hospitals. In a typical interchange, patients would insist on the quick discharge from the mental hospital, whereas the doctor usually responds with some form of disagreement. In this excerpt, we can see the typical proceeding from the patient insistence on discharge at 13P to the negative evaluation on the side of doctor at 14T. It is noted here that the psychiatrist regards this insistence on discharge as a typical one and asks the patient to give an adequate reason for discharge at 16T[11].

The sequence which starts at 16T to the end constitutes a reason for discharge for the patient, whereas this same sequence constitutes a clinical interview probing the patient's mental symptoms. And in this sequence, we can identify the two typical features of medical interview ; (1) pre-allocation of both turn types and distributions of them, (2) an asymmetry between the professionals and novice concerning the institutional task and purpose of the setting. Here, almost of all the psychiatrist's utterances are questions and those of patient are answers to the questions. This is a kind of professional control exerted over the novice. And we can identify the asymmetry or even the cleavage between the respective participants

concerning the agenda or plan of this interview. In addition, the doctor's institutional purpose of clarifying and describing the patient's mental symptoms has been kept hidden or implicit to the patient. Then what characterizes the doctor's activities of probing the mental symptoms from these interviews? Let us now look at this excerpt more closely[12].

The sequence of lines 18T-24T is different from the ordinary medical interview in that, although 17P is the answer to the doctor's question of 16T, 17P is not the expected answer; we can see the questioning sequences which starts from 18T's 'What?' to 22T's 'Whose clients?' These sequences are oriented to the clarification of the meaning of utterance 17P and in that sense, are organized as the dispreferred sequences to 17P's answer. If the appropriate answer for discharge were given by the patient, the next turn of the psychiatrist, i.e. the third turn from the first question, would constitute the evaluation of the appropriateness of that answer. However, this normative expectation is fallen short of, and the third turn evaluation is missing. And at 24T the ordinary medical interview seems to be beginning to start; 24T's question 'What do you mean?' starts the probing sequences to the end of this excerpt and the probing sequences can be characterized as specifically medical ones which transform the explication given by the patient into a case of 'troubles-talk'[13].

How is it that these sequences are medical or institutional ones? After doctor's repeated questions, 24T finally gets the patient's answer 'My thought is transmitted and what I see is seeable'. In ordinary conversation, the evaluation of some kind should be in order at this third turn. However, there could be found any evaluation to this answer. Instead, there comes the one second silence followed by the doctor's probing questions. Then the sequences of 24T-26T is found to be different from the ordinary reactions in that the patient answer as an newly introduced newsworthy topic gets no evaluation nor reciprocated second story form

the psychiatrist.

Moreover, we have to note the significance of the one second silence. In terms of the turn-taking system, this pause is identified as the result of the operation of 1c rule that the current speaker does not select next speaker nor the other participant selects himself as a next speaker, then the current speaker has the right to continue. In this case, 25P does not continue so that it produces one second pause and the psychiatrist tries to encourage the patient to continue the explication at 26T. It follows that the pause after the patient's explication is the doctor's strategy to make the patient continue. We can find the similar pause directly after 33P. And the pause following the patient's explication is a typical strategy found in medical interview.

The sequence of 24T-26T has the structure of question-answer-pause-further question and this structure makes it possible for the doctor to avoid any evaluation and encourage further explications from the patients. Here is one of the features of medical setting ; doctors express greater interest in troubles-tellers' problem than in their experiences with, or feelings about, their troubles. I would like to characterize this structure as peculiar to the institutionalized medical activities of eliciting troubles from the patient's explication and defining patient's troubles.

Here, closure of meaning of each utterance is systematically accomplished through the doctor's psychiatric expertise to elicit and define patient's troubles. Although the patient are trying to give some adequate reason for the quick discharge, his attempt itself constitutes the troubles-talk and is involved in the institutional question-answer-pause-further question sequences. Through these local activities, the psychiatrist constructs himself and the patient as appropriate medical objects in terms of the background psychiatric knowledge[14].

IV. Conclusion

Now we are in a position to make some contributions to the study of social problem. In social constructionist tradition, social problems are socially constructed through our claim making activities. However, as we reformulate indexicality in terms of the concept of cultural dope and Foucault, the seeming lack of claiming activities could be interpreted as the total government of fine power of culture ; in fact, the closure of meaning is being socially constructed in local social interactions and exerting the power effects to structure the possible future conducts. In this light, blending of ethnomethodology and Foucault opens up new possibilities to question the taken-for-granted world as problematic[15].

Notes

1) McHoul, A. W. 1994, The critical Ethnomethodology, *Theory, Culture and Society*, 11. See the related discussion in Yamada, T., 2000, *The Critique of Everyday Life – Schutz, Garfinkel and Foucault –*, Serica Shobo, Tokyo, Japan.

2) Garfinkel, H., 1967, *Studies in Ethnomethodology*, Prentice-Hall. p. 57. notes 8.

3) ibid. p. 35.

4) ibid. p. 57.

5) ibid. p. 68.

6) ibid. p. 70.

7) Foucault, M., 1982, "The Subject and Power", in Dreyfus, H. & Rabinow, P., *Michel Foucault : Beyond Structuralism and Hermeneutics*, Harvester Press, p. 217.

8) see Sacks., Sacks, H., "Hotrodder : A Revolutionary Category", in Psathas, G. (ed.), 1979, *Everyday Language : Studies in Ethnomethodology*, Irvington Publishers, pp. 7-14. For the related discussion, see my "An ethnomethodological attempt to the problem of the social control over identities", in Kurihara, A., ed., 1996, *The sociology of the discrimination, vol. I*, Koubundo Publishers, Tokyo, Japan.

9) For the datails of this fieldwork, see my "An ethnography of one mental hospital" in Yamada, T., and H., Yoshii, eds., 1991, *An Ethnomethodological Approach to the Phenomena of the Separatism and Discrimination*, Shin-yosha, Tokyo, Japan.

10) See Foucault, M., *The History of Sexuality*, Vol. I. 1978, Random House Inc.

11) To understand the typicalty of the topic of the discharge from the hospital, see now the classic Goffman, E., 1961, *The Asylum : Essays on the Social Situation on Mental Patients and Other Inmates*, Doubleday.

12) This summary of the clinical interviews is based on the Silvermans' concise explication, see Silverman, D., 1997, *Discourses of Counseling*, Sage Publications. And also for the framework of the talk in institutional settings, see Drew, P. & Heritage, J., Analyzing talk at Work : an introduction', in Drew, P. & Heritage, J. (eds.), 1992, *Talk at Work*, Cambridge University Press. p. 25.

13) For the formulation of the troubles talk, see Miller, G. and D. Silverman, 1995, Troubles Talk and Counseling Discourse : A comparative study', *Sociological Quarterly*, 36 : 37-59.

14) See other examples of professional dominance in Suchman, L., 1987, *Plans and Situated Actions*, Cambridge University Press.

15) Of course, this phrasing is taken from the famous Smith, D., 1989, *The Everyday World As Problematic : A Feminist Sociology, Northeastern University Press.*